

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

07519

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07510

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dor</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Secretary</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>09-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>Ely</u> Last <u>Baker</u>		4. DATE OF DEATH Month <u>5</u> Day <u>25</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/10/1884</u>
9. AGE (In years last birthday) <u>82</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Merrick</u>		14. MOTHER'S MAIDEN NAME <u>Louise Le Compte</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mr. Walter Merrick, Secretary</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4201</u> DUE TO <u>Coronary Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u>Generalized Arteriosclerosis</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. INTERVAL BETWEEN ONSET AND DEATH <u>11 hrs</u> <u>10 yrs</u> <u>20 yrs</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/21/55</u> , 19 <u> </u> to <u>5/25/66</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>5/22/66</u> , 19 <u> </u> , and that death occurred at <u>2:30 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Harold B. Plummer</u>		22b. DATE SIGNED <u>5/25/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Harold B. Plummer M.D.</u>		22d. ADDRESS <u>Preston Mary; and</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/28/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>	23d. LOCATION (City, town or county) (State) <u>East New Market Md</u>
24. FUNERAL DIRECTOR <u>Charles Judge</u>		25a. REC'D BY REGISTRAR <u>MAY 31 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

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01350

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
07520						07511					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN ID			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		
Talbot			Easton			14 DA			Memorial Hospital		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
workman						Bruceville, Md.			USA		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Thomas H. Brinsfield						Mary Parrott					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
no						217-03-7162		Mrs. Richard Lindeman		Easton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the colon											
1538 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m. 19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19, and that death occurred at 12:30 PM, from the causes and on the date stated above.											
22a. SIGNATURE Robert W. Trever											
22b. DATE SIGNED 5/25/66											
22c. PHYSICIAN'S NAME (Type) Robert W. Trever											
22d. ADDRESS M.D. Easton, Maryland											
23a. BURIAL, CREMATION, (Specify) 5/27/66											
23b. DATE THEREOF											
23c. NAME OF CEMETERY OR CREMATORY Spring Hill											
23d. LOCATION (City, town or county) (State) Easton, Md.											
24. FUNERAL DIRECTOR ADDRESS											
25a. REC'D BY REGISTRAR MAY 31 1966											
25b. REGISTRAR'S SIGNATURE Charles Judge											

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113 G. Park St.

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Greenwich, No.

London

Thomas H. Bywater

Harry Bywater

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Mr. Michael Lindsay, London, No.

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London, No.

London, No.

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London

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London, No.

London, No.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07521

07512

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL EASTON			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS CHAPEL ROAD			
3. NAME OF DECEASED (Type or print) First JAMES Middle BYRD Last Brooks Sr.				4. DATE OF DEATH Month May Day 6 Year 1966			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOVEMBER 26, 1885	
9. AGE (in years last birthday) 80 yrs.		10. MONTHS 5 DAYS 10 HOURS MIN. 		11. BIRTHPLACE (County & State, or foreign country) BIG RUN-PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING				10b. KIND OF BUSINESS OR INDUSTRY RETIRED			
13. FATHER'S NAME John O. Brooks				14. MOTHER'S MAIDEN NAME CATHARINE A. HOLLOWELL			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 217-36-0881		17. INFORMANT John O. Brooks Address EASTON - R.D. - MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 4201 DUE TO (b) Coronary atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 7 (?)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 29 Apr , 19 66 , to 6 May , 19 66 , that (I) (we) last saw the deceased alive on 6 May , 19 66 , and that death occurred at 10:45 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Thompson Harrison						22b. DATE SIGNED 9 May 66	
22c. PHYSICIAN'S NAME (Type or print) THOMPSON HARRISON				22d. ADDRESS Easton, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) MAY 9, 1966		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY SPRING HILL		23d. LOCATION (City, town or county) (State) EASTON - MARYLAND	
24. FUNERAL DIRECTOR Charles Judge				25a. REC'D BY REGISTRAR MAY 11 1966 25b. REGISTRAR'S SIGNATURE Charles Judge			

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VR A15 (4)
20M 1/65

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07522

07513

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CENTREVILLE</u>	
c. LENGTH OF STAY IN 1b <u>5 WKS.</u>		d. STREET ADDRESS <u>102 KIDWELL AVE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOUSE IN THE PINES, EASTON</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>ELIZA</u> Last <u>Brown</u>		4. DATE OF DEATH Month <u>May</u> Day <u>4</u> Year <u>1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 26-1885</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>CAROLINE Co. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE T. FAITHFUL</u>		14. MOTHER'S MAIDEN NAME <u>LOUISA JANE SPARKS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>216-38-9888A</u>	
17. INFORMANT <u>MRS. PRISCILLA B. ZWITZER</u>		Address <u>ANNAPOLIS MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>aspiration pneumonia</u> 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Recurrent cerebral thrombosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>8 days</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12 March 1966</u> to <u>4 May 1966</u> , that (I) (we) last saw the deceased alive on <u>May 4</u> 1966, and that death occurred at <u>4:50 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Stephen Carney</u>		22b. DATE SIGNED <u>4 May 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>STEPHEN CARNEY</u>		22d. ADDRESS <u>EASTON MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
<u>BURIAL</u>	<u>MAY 6</u>	<u>CHESTERFIELD</u>	<u>CENTREVILLE MD.</u>
24. FUNERAL DIRECTOR <u>Edgar L. Lane</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>CHURCH HILL MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>MAY 9 1966</u>			

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07528

CERTIFICATE OF DEATH

07514

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY Talbot b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) (Cordova (rural)) c. LENGTH OF STAY IN ID 47 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) RFD # 1				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cordova (rural) d. STREET ADDRESS RFD # 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Joseph Callahan First Middle Last				4. DATE OF DEATH 5/11 19 66 Month Day Year			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/28/1892	
9. AGE (In years last birthday) 73 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Talbot Maryland	
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME James A. Callahan		14. MOTHER'S MAIDEN NAME Louise Greaves		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 218-16-5756		17. INFORMANT Mrs. Joseph Callahan, Cordova, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the stomach 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from May , 19 66 , to June , 19 66 , that (I) last saw the deceased alive on 5/10 19 66 , and that death occurred at M , from the causes and on the date stated above.	
22a. SIGNATURE Irvin G. Hoyt		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Irvin G. Hoyt MD		22d. ADDRESS Queenstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/14/1966		23c. NAME OF CEMETERY OR CREMATORY Spring Hill		23d. LOCATION (City, town, or county) (State) Easton, Md.	
24. FUNERAL DIRECTOR MALROUCE E. NEUNHAM & SON, Easton, Md.		25a. REC'D BY REGISTRAR MAY 17 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

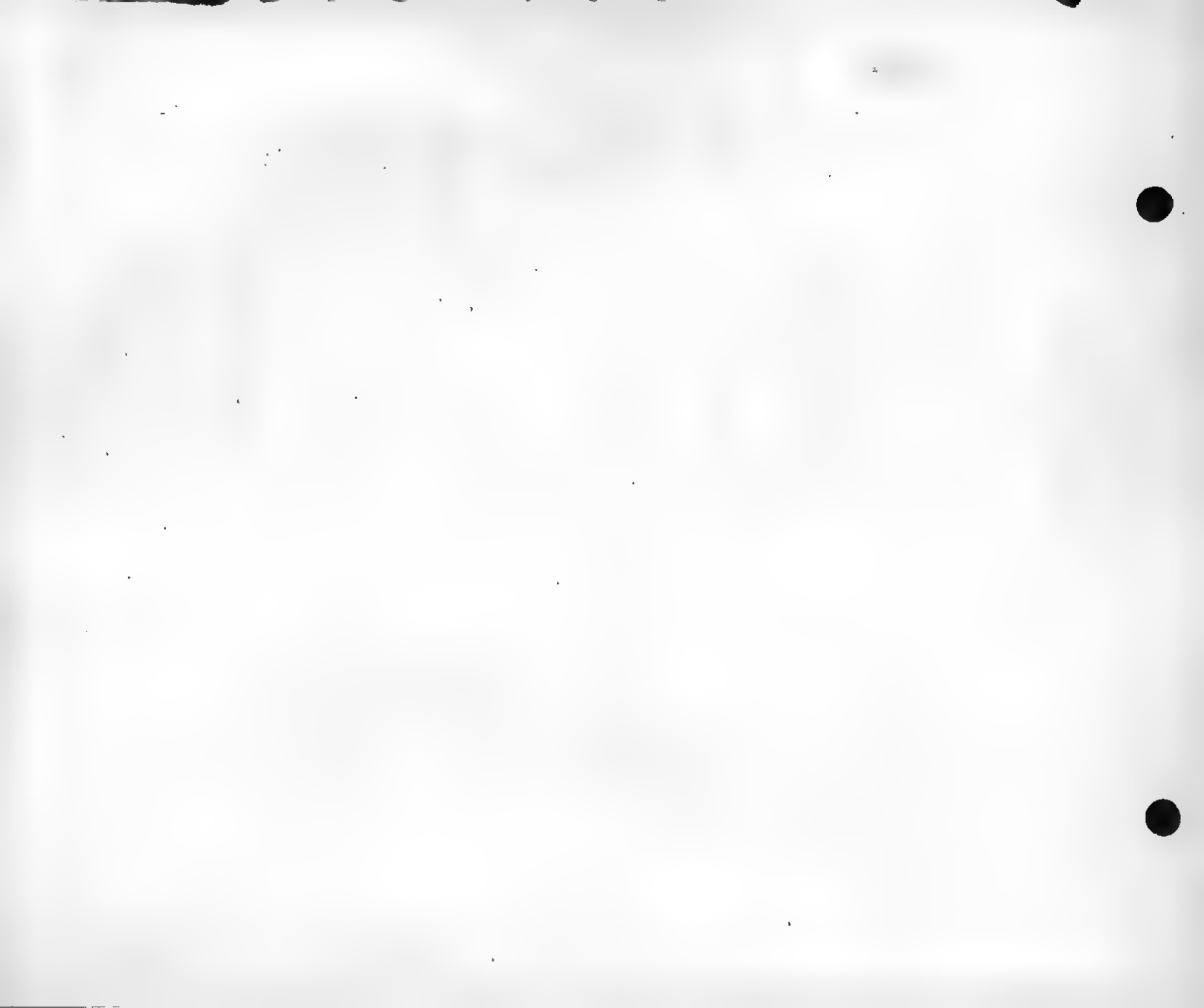
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07524

07515

1. PLACE OF DEATH a. COUNTY <i>Chilton</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. <i>Maryland</i> b. COUNTY <i>Queen Anne</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Chilton</i>		c. LENGTH OF STAY IN 1b <i>3 hr.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Memorial Hospital</i>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <i>Elena</i> Middle <i>E.</i> Last <i>Callahan</i>		4. DATE OF DEATH Month <i>5</i> Day <i>17</i> Year <i>1966</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 24, 1904</i>
9. AGE (In years last birthday) <i>62</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Greenfield, New Jersey</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Walter Sharp</i>		14. MOTHER'S MAIDEN NAME <i>Mary Goldie Montimer</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>H.F. Addison Callahan</i>		Address <i>Church Hill, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septicemia due to</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <i>abscess in lesser sac due to</i> DUE TO (c) <i>Ruptured gall bladder</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 hrs.</i> (?) (?)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>5 May</i> , 19 <i>66</i> , to <i>17 May</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>17 May</i> , 19 <i>66</i> , and that death occurred at <i>20</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Thurston Harrison</i>		22b. DATE SIGNED <i>18 May 66</i>	
22c. PHYSICIAN'S NAME (Type) <i>THURSTON HARRISON</i>		22d. ADDRESS <i>Easton, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 21</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Church Hill</i>		23d. LOCATION (City, town or county) (State) <i>Church Hill, Maryland</i>	
24. FUNERAL DIRECTOR <i>Edgar L. Lane</i>		25a. REC'D BY REGISTRAR <i>MAY 24 1966</i>	
ADDRESS <i>Church Hill, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	



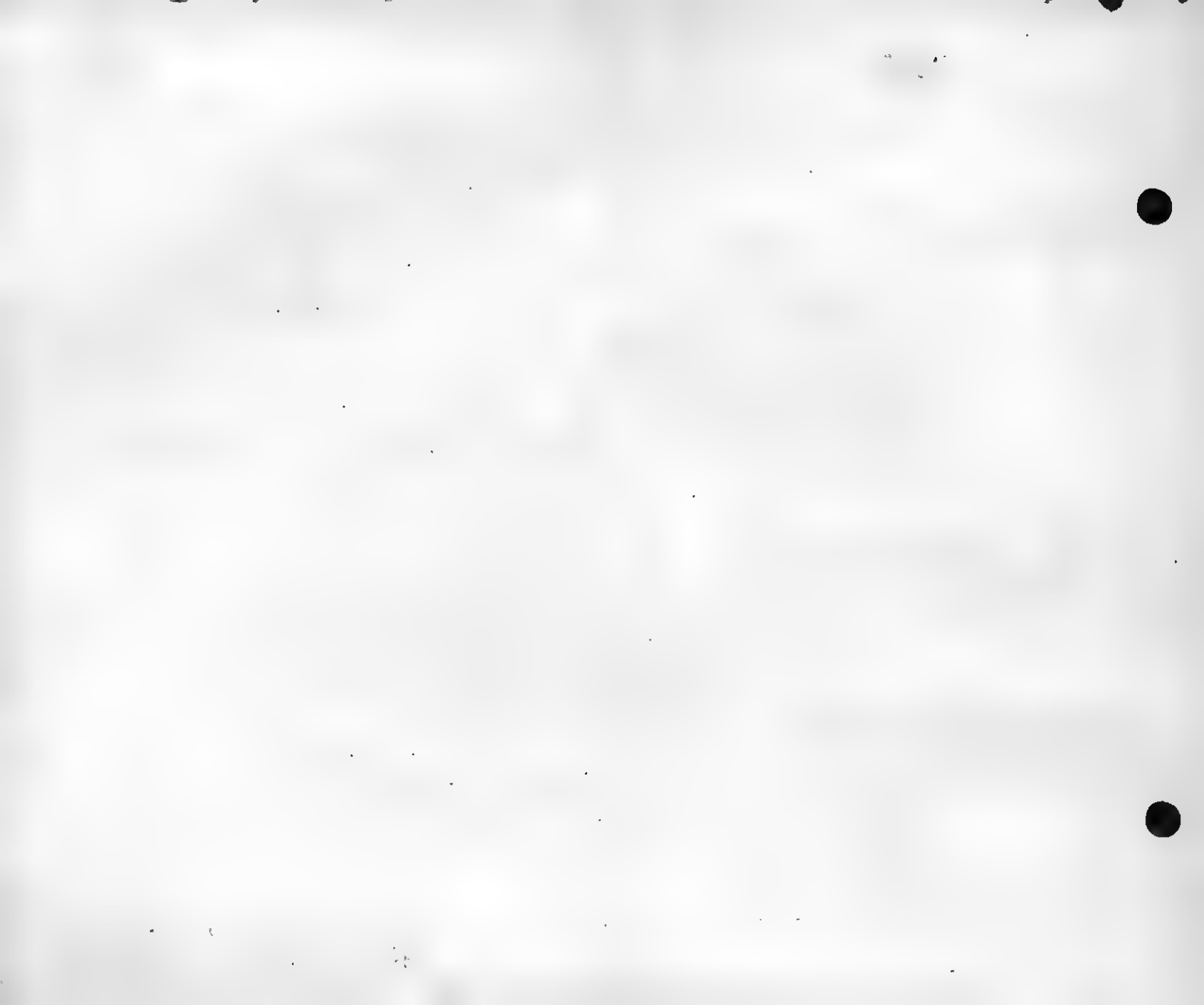
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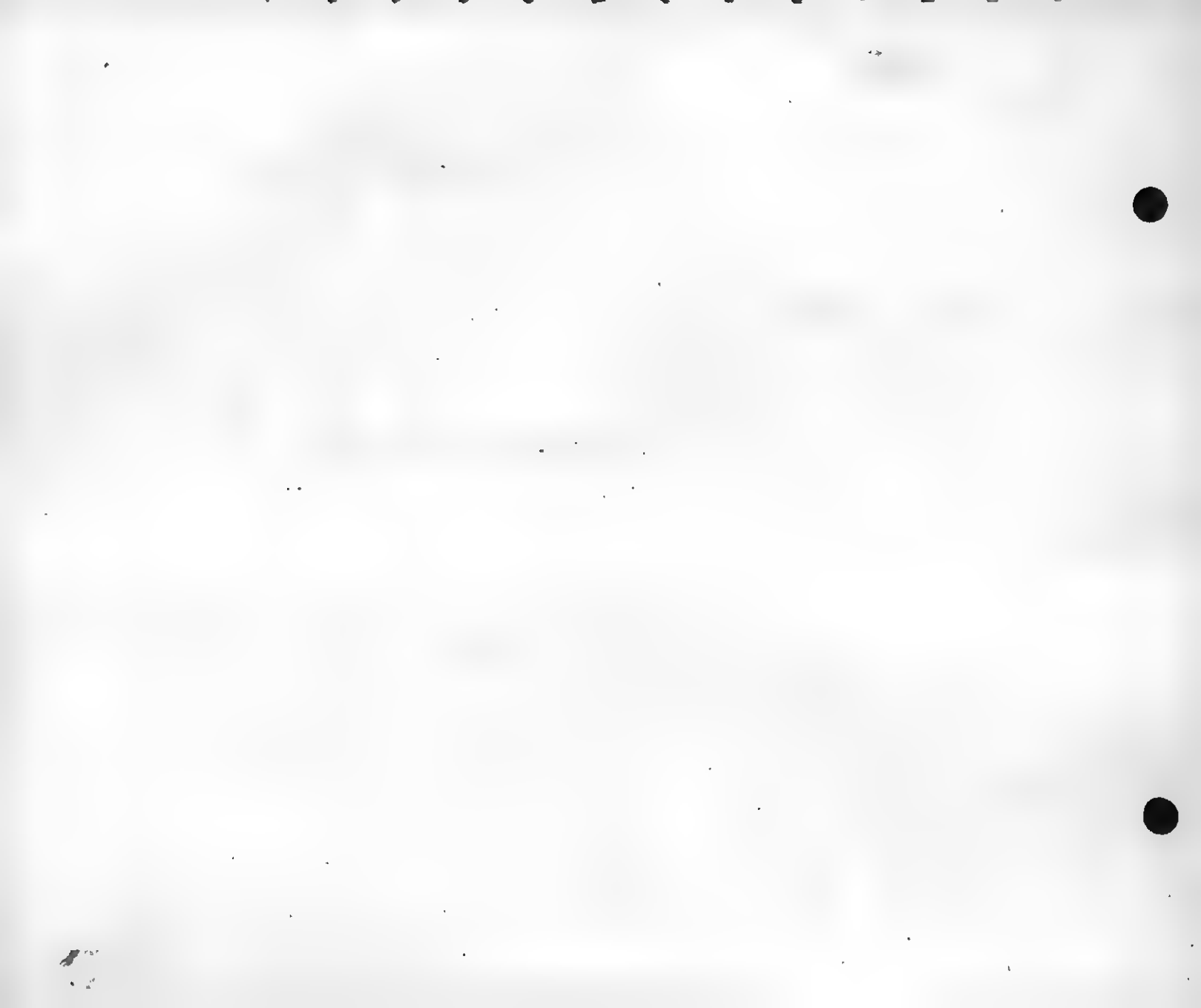
1. PLACE OF DEATH a. COUNTY <u>Talbot</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Tell</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN lb <u>9da</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memor. Al Hospital</u>		e. STREET ADDRESS <u>Route 4, Box 115</u>	
3. NAME OF DECEASED (Type or print) <u>Jack</u>		4. DATE OF DEATH Month <u>5</u> - Day <u>8</u> - Year <u>1966</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCTOBER 17, 1900</u>	
9. AGE (in years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>8</u> Hours <u>15</u> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Executive</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Orvis Caswell</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Stutte</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>- - -</u>		16. SOCIAL SECURITY NO. <u>- - -</u>	
17. INFORMANT <u>Jane Parker Caswell - Sec Item #2.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Probable myocardial infarction</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August, 1965</u> to <u>8 May, 1966</u> , that (I) (we) last saw the deceased alive on <u>7 May 1966</u> , and that death occurred at <u>7:15 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Stephen P. Carney</u>		22b. DATE SIGNED <u>8 May 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Charles J. ...</u>		22d. ADDRESS <u>...</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>5-10-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Switzland, Ma</u>	
24. FUNERAL DIRECTOR <u>Lawrence Funeral Home - 5135 Wisconsin Ave.</u>		25a. REC'D BY REGISTRAR <u>MAY 12 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>																							
1. PLACE OF DEATH a. COUNTY <u>ALBET</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EAston</u> c. LENGTH OF STAY IN ID <u>8 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>memoria Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNES</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL QUEENSTOWN</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) First <u>Rita</u> Middle <u>Weller</u> Last <u>Cherrington</u>			4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1966</u>			5. SEX <u>FEMALE</u>			6. COLOR OR RACE <u>WHITE</u>			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>Sept. 7, 1896</u>			9. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>						11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>																	
13. FATHER'S NAME <u>Joseph I. Weller</u>						14. MOTHER'S MARDEN NAME <u>Charlotte McCarthy</u>																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>216-34-0812</u>						17. INFORMANT Address <u>Edwin N. Cherrington, Queenstown, Md.</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis - left</u> <u>332X</u> DUE TO <u>hemiplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)																	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>29 Apr</u> , 19 <u>66</u> , to <u>7 May</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>MAY 7</u> , 19 <u>66</u> , and that death occurred at <u>7th</u> M, from the causes and on the date stated above.																							
22a. SIGNATURE <u>Thurston Harrison</u>												22b. DATE SIGNED <u>9 May 66</u>											
22c. PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>												22d. ADDRESS <u>Easton, Maryland</u>											
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u>						23b. DATE THEREOF <u>May 9, 1966</u>						23c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Church Cemetery</u>						23d. LOCATION (City, town or county) (State) <u>QUEENSTOWN MD.</u>					
24. FUNERAL DIRECTOR <u>James H. Babin, Jr., Baltimore, Md.</u>												25a. REC'D BY REGISTRAR <u>MAY 13 1966</u>						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

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07527

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07518

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u> c. LENGTH OF STAY IN 1b <u>3 1/2</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Trappe, Md.</u> d. STREET ADDRESS <u>THIRTEEN RURAL</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph Harper Cox</u> First Middle Last 4. DATE OF DEATH <u>5 11 1966</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>12/11/1890</u> 9. AGE (in years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>Talbot, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>J. Lacy Cox</u> 14. MOTHER'S MAIDEN NAME <u>Mary E. Price</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>220-34-7515</u> 17. INFORMANT <u>Carrie Saulsbury Cox Trappe, Md.</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the bladder</u> 1810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>March 1965</u> to <u>11 May 1966</u> , that (I) (we) last saw the deceased alive on <u>10 May 1966</u> , and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Stephen P. Carney, M.D.</u> 22b. DATE SIGNED <u>5-11-66</u> 22c. PHYSICIAN'S NAME (Type) <u>Stephen P. Carney, M.D.</u> 22d. ADDRESS <u>Easton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> 23b. DATE THEREOF <u>5/13/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Easton Hill</u> 23d. LOCATION (City, town or county) (State) <u>Easton Talbot, Md.</u>		24. FUNERAL DIRECTOR <u>J. D. Hume</u> 25a. REC'D BY REGISTRAR <u>MAY 16 1966</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and no day event, within 72 hours after death.

VR A15 (4)
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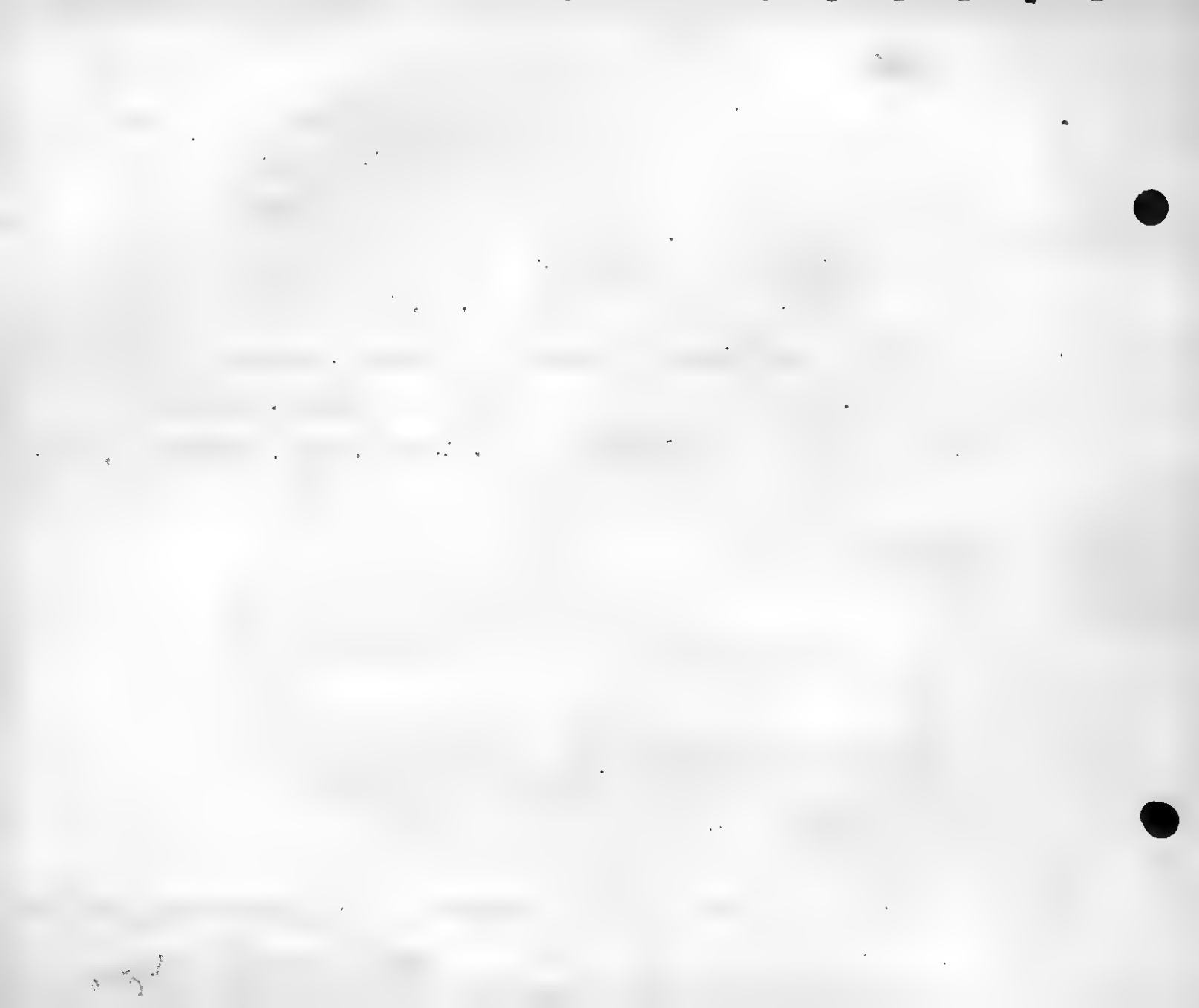
MARYLAND STATE DEPARTMENT OF HEALTH										07519	
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										07519	
07528											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Talbot b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Easton c. LENGTH OF STAY IN ID 3 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Talbot c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Tunis Mills, Md. d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Jennie Mae Daffin			4. DATE OF DEATH May 11 1966			5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Caroline			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Rickardson					14. MOTHER'S MAIDEN NAME unk.						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 218-34-9952			17. INFORMANT William Carlton Daffin, Tunis Mills					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction + x o i DUE TO (b) atherosclerotic coronary DUE TO (c) arteriosclerosis CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.										INTERVAL BETWEEN ONSET AND DEATH 72 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes m.											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from March 1966 to May 11, 1966 , that (I) (we) last saw the deceased alive on May 11 1966 , and that death occurred at 2:15 AM , from the causes and on the date stated above.											
22a. SIGNATURE Wm. M. Preater			22b. DATE SIGNED 5-11-66			22c. PHYSICIAN'S NAME (Type) Wm. M. Preater			22d. ADDRESS Adm. Michael, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) burial			23b. DATE THEREOF 5/13/66		23c. NAME OF CEMETERY OR CREMATORY Spring Hill		23d. LOCATION (City, town or county) (State) Easton, Md.				
24. FUNERAL DIRECTOR James D. Howard, Easton, Md.			25a. REC'D BY REGISTRAR MAY 16 1966		25b. REGISTRAR'S SIGNATURE Charles Judge						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
07523						07520					
1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Caroline</i> ✓					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>				c. LENGTH OF STAY IN 1b <i>2 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Federalsburg</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial</i>						d. STREET ADDRESS <i>Maple Avenue</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH		Month	Day	Year	
<i>Preston James Davis</i>						<i>Nov. 19, 1907</i>		<i>5</i>	<i>7</i>	<i>1966</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>Nov. 19, 1907</i>		9. AGE (In years last birthday) <i>58</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Truck Owner - Long Distance Truck Hauling</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Salisbury, Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>James C. Davis</i>						14. MOTHER'S MAIDEN NAME <i>Betty S. Hastings</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>215-12-6312</i>		17. INFORMANT <i>Mrs. Carrie M. Davis, Federalsburg, Md.</i> RED					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of the lung</i> <i>163x</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>1 Dec</i> , 19 <i>65</i> to <i>7 May</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>5-7</i> , 19 <i>66</i> , and that death occurred at <i>9:45</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>Stephen P. Curran</i>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS <i>7 May 66</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>May 11, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cokesbury Cemetery</i>				23d. LOCATION (City, town or county) (State) <i>Near Federalsburg, Maryland</i>			
24. FUNERAL DIRECTOR <i>from Frankton, Jr. Federalsburg, Maryland</i>						25a. REC'D BY REGISTRAR <i>MAY 12 1966</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div> <div>1</div> <div>M</div> </div> <div> <div>07530</div> <div>37521</div> </div>									
<div> <div>1</div> <div>2</div> </div> <div> <div>3</div> <div>4</div> </div>									
<div>1. PLACE OF DEATH</div> <div>a. COUNTY</div> <div>TALBOT</div> <div>MARYLAND</div>					<div>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</div> <div>a. STATE</div> <div>Maryland</div> <div>b. COUNTY</div> <div>Caroline</div>				
<div>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</div> <div>EASTON</div>					<div>c. LENGTH OF STAY IN ID</div> <div>3 days 4 hrs.</div>				
<div>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</div> <div>Memorial</div>					<div>e. IS RESIDENCE ON A FARM?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>				
<div>3. NAME OF DECEASED (Type or print)</div> <div>First</div> <div>Wilbert</div> <div>Middle</div> <div>Ernest</div> <div>Last</div> <div>Downes</div>					<div>4. DATE OF DEATH</div> <div>Month</div> <div>5</div> <div>Day</div> <div>17</div> <div>Year</div> <div>1966</div>				
<div>5. SEX</div> <div>male</div>		<div>6. COLOR OR RACE</div> <div>White</div>		<div>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/></div>		<div>8. DATE OF BIRTH</div> <div>12-28-1898</div>		<div>9. AGE (In years last birthday)</div> <div>67 yrs.</div>	
<div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>Retired Farmer</div>				<div>10b. KIND OF BUSINESS OR INDUSTRY</div> <div>None</div>		<div>11. BIRTHPLACE (County & State, or foreign country)</div> <div>Maryland</div>		<div>12. CITIZEN OF WHAT COUNTRY?</div> <div>USA</div>	
<div>13. FATHER'S NAME</div> <div>Ernest Downes</div>					<div>14. MOTHER'S MAIDEN NAME</div> <div>Ella Tribbitt</div>				
<div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</div> <div>No</div>		<div>16. SOCIAL SECURITY NO. (If yes give war or dates of service)</div> <div>220-09-1933</div>		<div>17. INFORMANT</div> <div>Address</div> <div>Malone Downes Newark, Delaware</div>					
<div>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>Cerebral Thrombosis</div> <div>(b)</div> <div>Cerebral arteriosclerosis</div> <div>(c)</div> <div>Unertain</div>									<div>INTERVAL BETWEEN ONSET AND DEATH</div> <div>3 days</div>
<div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</div>									<div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>
<div>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</div>					<div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</div>				
<div>20c. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>Hour a.m.</div> <div>p.m.</div> <div>19</div>			<div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></div>		<div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div>		<div>20f. (City or town) (County) (State)</div>		
<div>21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 1:30 AM, from the causes and on the date stated above.</div>									
<div>22a. SIGNATURE</div> <div>Robert W. Trever</div>					<div>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></div> <div>M.D.</div>		<div>22b. DATE SIGNED</div> <div>5/17/66</div>		
<div>22c. PHYSICIAN'S NAME (Type)</div> <div>Robert W. Trever</div>					<div>22d. ADDRESS</div> <div>Easton, Maryland</div>				
<div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div>		<div>23b. DATE THEREOF</div> <div>5-20-66</div>		<div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Mt. Olive</div>		<div>23d. LOCATION (City, town or county) (State)</div> <div>Sandtown, Delaware</div>			
<div>24. FUNERAL DIRECTOR</div> <div>ADDRESS</div> <div>J. E. Bouclair's Greensboro Md</div>					<div>25a. REC'D BY REGISTRAR</div> <div>MAY 19 1966</div>		<div>25b. REGISTRAR'S SIGNATURE</div> <div>Charles Judge</div>		



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please place above carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY TALBOT				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY QUEEN ANNES				3. DATE Month MAY Day 15 Year 1966			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON				c. LENGTH OF STAY IN LD 28 hrs				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) QUEENSTOWN			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle Connelly Last Saul Knec				4. DATE Month MAY Day 15 Year 1966				5. SEX Female			
6. COLOR OR RACE White				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH JANUARY 18, 1905			
9. AGE (In years last birthday) 61 yrs.				10. BIRTHPLACE (County & State, or foreign country) Centerville, Q.A.C., Md.				11. CITIZEN OF WHAT COUNTRY? U.S.A.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEACHER				10b. KIND OF BUSINESS OR INDUSTRY Public School				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME DANIEL G. CONNELLY				14. MOTHER'S MAIDEN NAME IDA E. COURSEY				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. 215-38-0218				17. INFORMANT Thomas Milton Faulkner, Queenstown, Md.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 3014 DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 36 hrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 14 May , 19 66 , to 15 May , 19 66 , that (I) (we) last saw the deceased alive on May 15 , 19 66 , and that death occurred at 5:25 PM , from the causes and on the date stated above.											
22a. SIGNATURE Thorston Harrison				22b. DATE SIGNED 16 May 66				22c. PHYSICIAN'S NAME (Type) THORSTON HARRISON			
22d. ADDRESS Charm, Mayland				22e. REC'D BY REGISTRAR MAY 23 1966				22f. REGISTRAR'S SIGNATURE Charles Judge			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF May 18, 1966				23c. NAME OF CEMETERY OR CREMATORY Old Wye Church Cemetery			
23d. LOCATION (City, town or county) (State) Wye Mills, Maryland				23e. REC'D BY REGISTRAR MAY 23 1966				23f. REGISTRAR'S SIGNATURE Charles Judge			



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1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07532

CERTIFICATE OF DEATH

07523

1. PLACE OF DEATH a. COUNTY Talbot			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Easton			c. LENGTH OF STAY IN 1b 8 mos.		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) House In The Pines Easton			d. STREET ADDRESS Route #3 Box 95		
3. NAME OF DECEASED (Type or print) First Esta Middle May Last Harrison			4. DATE OF DEATH Month May Day 6 Year 1966		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/29/1886	9. AGE (In years last birthday) 78 yrs.	10. UNDER 1 YEAR Months 8 Days 10 Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) TILGHMAN, TALBOT, M.D.	
13. FATHER'S NAME JOHN T. MAU			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) X			16. SOCIAL SECURITY NO. 216-46-0286		
17. INFORMANT P. LINWOOD HARRISON			Address TILGHMAN, M.D.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic congestive heart failure 4300 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) 					INTERVAL BETWEEN ONSET AND DEATH 8 months many yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from Sept , 19 65 to 6 May , 19 66 , that (I) (we) last saw the deceased alive on 7 May , 19 66 , and that death occurred at 10:30 P.M. , from the causes and on the date stated above.					
22a. SIGNATURE Stephen P. Carney			22b. DATE SIGNED 7 May 66		
22c. PHYSICIAN'S NAME (Type) STEPHEN P. CARNEY, M.D.			22d. ADDRESS EASTON - MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF MAY 9, 66	23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery - Sherwood	23d. LOCATION (City, town or county)	(State)	
24. FUNERAL DIRECTOR Charles Judge	25a. REC'D BY REGISTRAR MAY 11 1966	25b. REGISTRAR'S SIGNATURE Charles Judge			



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(M)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07533

7524

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>26 1/2 hr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>500 W. University Pkwy.</u>	
3. NAME OF DECEASED (Type or print) <u>Charles James Hartle</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4. DATE OF DEATH Month <u>5</u> Day <u>9</u> Year <u>1966</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Exec. Maryland Specialty Wine Co.</u>		8. DATE OF BIRTH <u>2/20/1908</u>	
10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>58</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) <u>West Chester N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Hartle</u>		14. MOTHER'S MAIDEN NAME <u>Alice Green</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>11</u>		16. SOCIAL SECURITY NO. <u>163-03-1123</u>	
17. INFORMANT <u>Mrs. Charles J. Hartle, Baltimore, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>DUE TO</u> (c) <u>DUE TO</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8 May</u> , 19 <u>66</u> to <u>9 May</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>9 May</u> , 19 <u>66</u> , and that death occurred at <u>10:45</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Stephen P. Carney</u>		22b. DATE SIGNED <u>9 May 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stephen P. Carney</u>		22d. ADDRESS <u>Easton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/12/1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>	
24. FUNERAL DIRECTOR <u>Maurice E. Neumann & Son Easton, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 11 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH

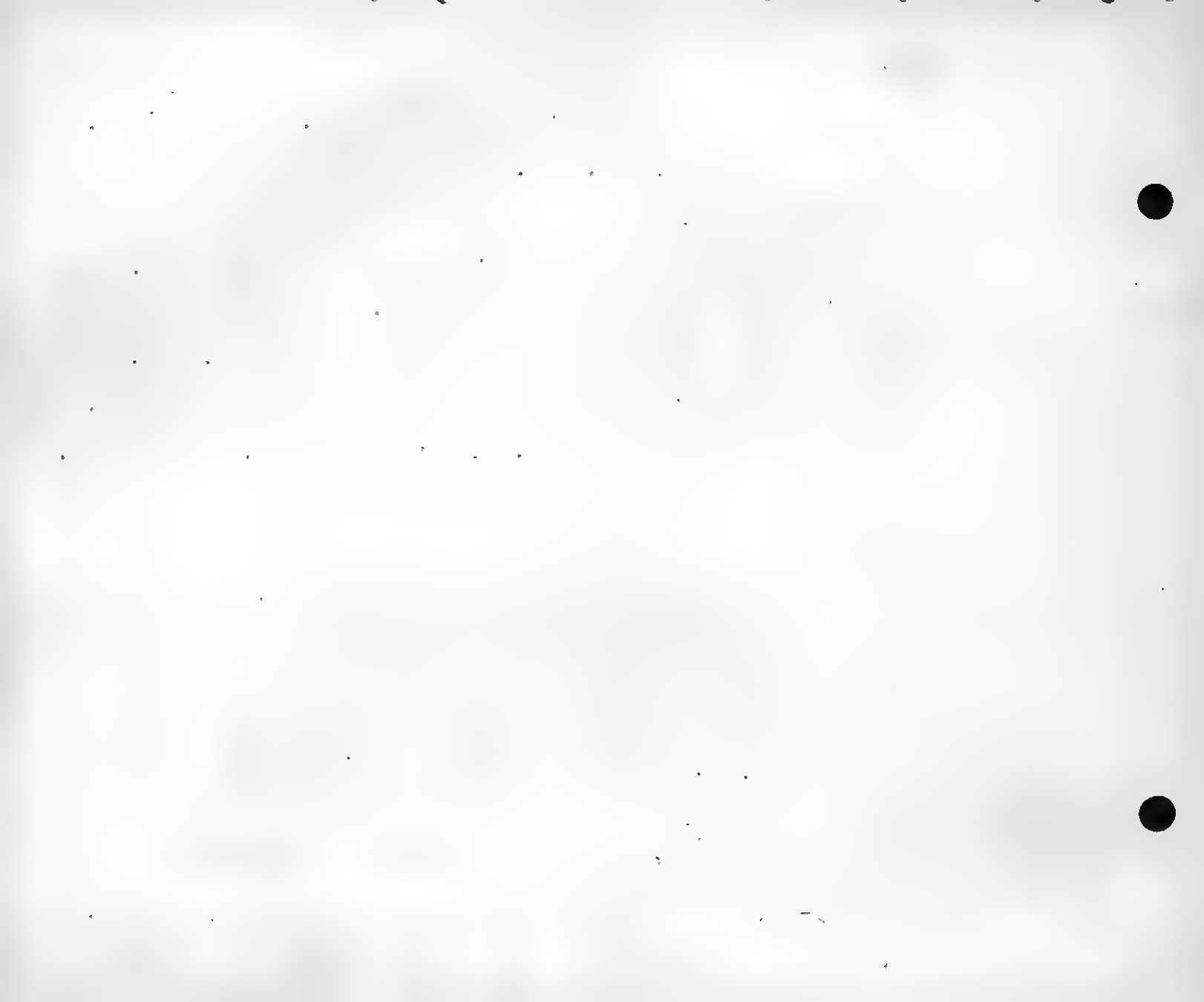
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07534

17523

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Talbot.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton.</u>		c. LENGTH OF STAY IN 1b <u>2 yrs. 7 mo.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton.</u>		d. STREET ADDRESS <u>Route #3 Box 95</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>House in the Pines.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas Hughlett Henry</u>		4. DATE OF DEATH Month Day Year <u>5-14-1966</u> <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/5/1879.</u>
9. AGE (In years last birthday) <u>86 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lawyer & Banker</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Talbot, Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Campbell Henry</u>		14. MOTHER'S MAIDEN NAME <u>Maria Elizabeth Hughlett.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>713-01-8704</u>	
17. INFORMANT <u>T. Hughlett Henry Jr.</u>		Address <u>Easton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> 4 - 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cronary atherosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> (?)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>46</u> , to <u>14 May</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>14 May</u> , 19 <u>66</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Horston Harrison</u>		22b. DATE SIGNED <u>16 May 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>HORSTON HARRISON</u>		22d. ADDRESS <u>Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-16, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		23d. LOCATION (City, town or county) (State) <u>Easton, Maryland.</u>	
24. FUNERAL DIRECTOR <u>Willie Cook</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Easton, Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
MAY 18 1966			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07535

07526

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>			
c. LENGTH OF STAY IN 1b <u>Life</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Betty A. Hyanson</u>			4. DATE OF DEATH Month <u>5</u> Day <u>21</u> Year <u>1966</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 14 - 1913</u>	9. AGE (in years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR: Months <u>5</u> Days <u>21</u> Hours <u>19</u> Min. <u>66</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Eugene Smith</u>				14. MOTHER'S MARDEN NAME <u>Levina Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>218-07-7224</u>		17. INFORMANT <u>Jesse Caldwell</u>		Address <u>Wittman, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4201</u> DUE TO <u>atherosclerotic coronary a.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>atherosclerotic coronary a.</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes m.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-21-66</u> to <u>5-21-66</u> , that (I) (we) last saw the deceased alive on <u>5-21-66</u> , and that death occurred on <u>5-21-66</u> at <u>5:15</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>5-27-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Lucy M. Reaker Jr.</u>				22d. ADDRESS <u>St. Michaels Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>5-25-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>C. Thomas mem. Cem.</u>		23d. LOCATION (City, town or county) (State) <u>St. Michaels Md.</u>	
24. FUNERAL DIRECTOR <u>James O. Doshier, Porton, Md.</u>				25a. REC'D BY REGISTRAR <u>JUN 3 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

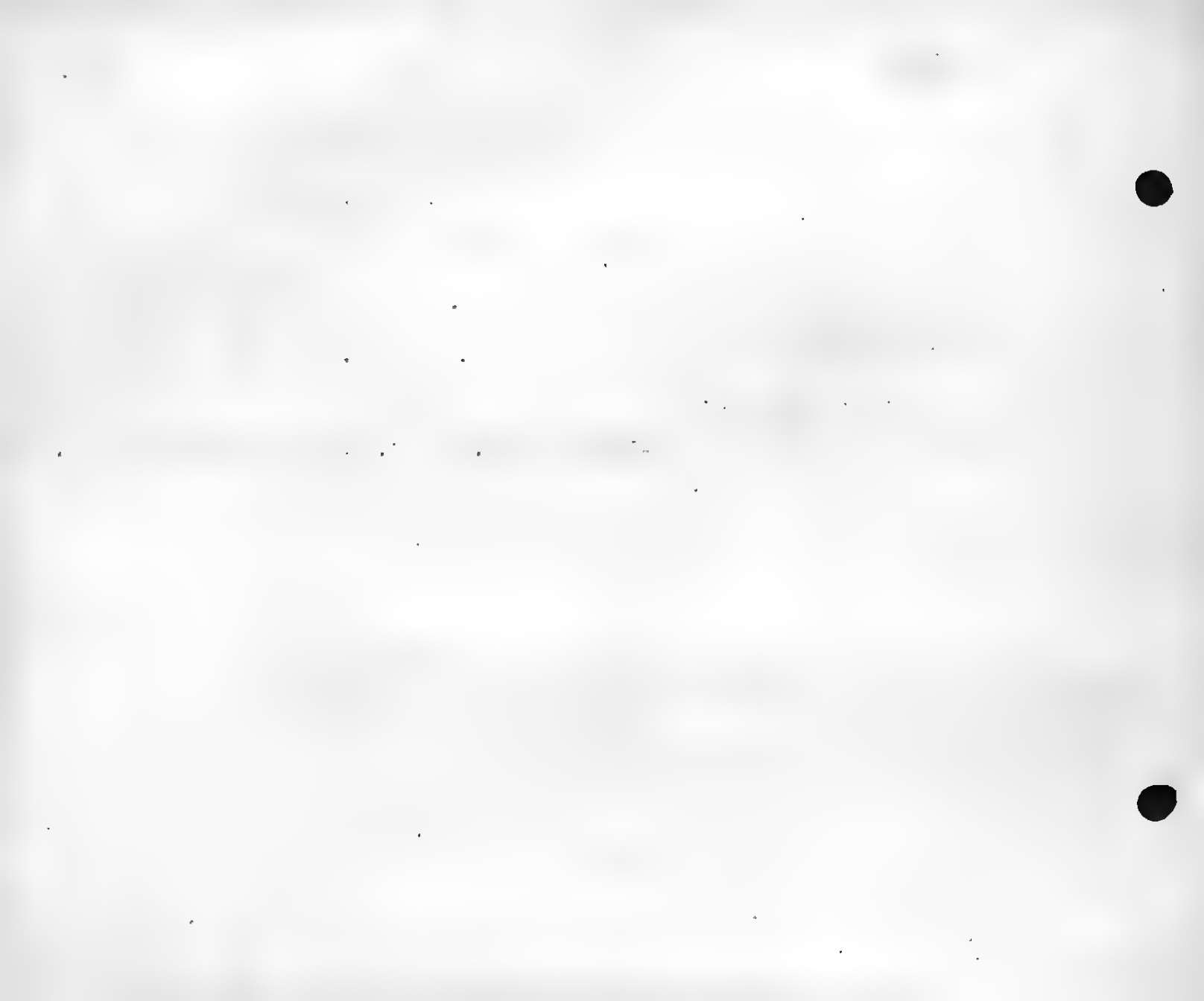


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
C7536					07527				
1. PLACE OF DEATH a. COUNTY <i>Talbot</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Caroline</i> ✓				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Federalburg</i>			c. LENGTH OF STAY IN 1b <i>7 days</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Federalburg - Rural</i>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Memorial</i>					d. STREET ADDRESS <i>Bridgeville Road</i>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Carl</i> First <i>Tilghman</i> Middle <i>T.</i> Last <i>Johnson</i>					4. DATE OF DEATH Month <i>5</i> Day <i>6</i> Year <i>1966</i>				
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept. 17, 1891</i>		9. AGE (In years last birthday) <i>74</i> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Farmer and Carpenter</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Caroline Co., Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>James Willard Johnson</i>					14. MOTHER'S MAIDEN NAME <i>Ida Scott</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>N</i>				16. SOCIAL SECURITY NO. <i>218-12-6417</i>		17. INFORMANT <i>Mrs. Gula A. Johnson, Federalburg, Md., RFD</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ruptured aortic aneurysm</i> <i>451X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Advanced arteriosclerosis</i> DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) this hospital attended the deceased from <i>1966</i> to <i>1966</i> , that (I) (we) last saw the deceased alive on <i>May 8, 1966</i> , and that death occurred at <i>5 PM</i> , from the causes and on the date stated above.									
22a. SIGNATURE <i>E. C. H. Schmidt</i>					22b. DATE SIGNED <i>5-6-66</i>				
22c. PHYSICIAN'S NAME (Type) <i>E. C. H. Schmidt</i>					22d. ADDRESS <i>Caroline, Maryland</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>May 8, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Hill Crest Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Federalburg, Maryland</i>		
24. FUNERAL DIRECTOR <i>Tramptson Funeral Home Federalburg</i>					25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07537

07528

1. PLACE OF DEATH a. COUNTY <u>Talbot</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN ID <u>56 hrs</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Queen Anne's</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prasonville, Md.</u>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year			
5. SEX <u>F</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 28, 1894</u>		9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sea Food</u>		11. BIRTHPLACE (State or foreign country) <u>Upper Hill, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Samuel P. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Turpin</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-07-6843</u>		17. INFORMANT <u>Alexander Johnson</u> Address <u>Prasonville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4500 Congestive Heart Failure with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Julimany Bacteria</u> (c) <u>For Dilated Aortic Arteriosclerosis</u>												INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <u>C. R. Payton</u>				M.D.				22. DATE SIGNED <u>5-19-66</u>									
EXAMINER'S NAME (Type) <u>C. R. Payton</u>				Address (Street, city, town, or county) <u>Centerville Md</u>													
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF <u>5-20-66</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Upper Hill, Md</u>				23d. LOCATION (City, town or county) (State) <u>Upper Hill Md.</u>					
24. FUNERAL DIRECTOR <u>James B. Washell</u>				ADDRESS <u>Easton Md</u>				25a. REC'D BY REGISTRAR <u>MAY 24 1966</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
C7538					07529				
1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> c. LENGTH OF STAY IN MD <u>6 days 10 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MEMORIAL</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL GREENSBORO</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALEXANDER B. KARPINSKI</u>			4. DATE OF DEATH Month Day Year <u>5 8 1966</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>April 18, 1907</u> 9. AGE (in years last birthday) <u>59</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SAND + GRAVEL</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>OWNER</u>		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>ALEXANDER KARPINSKI</u>					14. MOTHER'S MAIDEN NAME <u>AGNES HELMINIAK</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>Mrs. ALEXANDER KARPINSKI, GREENSBORO</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u> <u>332X</u> OUE TO (b) <u>Cerebral thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>7 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>10 March, 1966</u> to <u>8 May, 1966</u> , that (I) (we) last saw the deceased alive on <u>8 May, 1966</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Stephen P. Carney</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10 May 66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Stephen P. Carney</u>				M.D. ADDRESS <u>Easton, Maryland</u>		10 May 66			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <u>MAY 11, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>14024 CROSS</u>		23d. LOCATION (City, town or county) (State) <u>GREENSBORO MD.</u>		
24. FUNERAL DIRECTOR <u>Charles V. Leone Denton</u>				ADDRESS		25a. REC'D BY REGISTRAR <u>MAY 13 1966</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

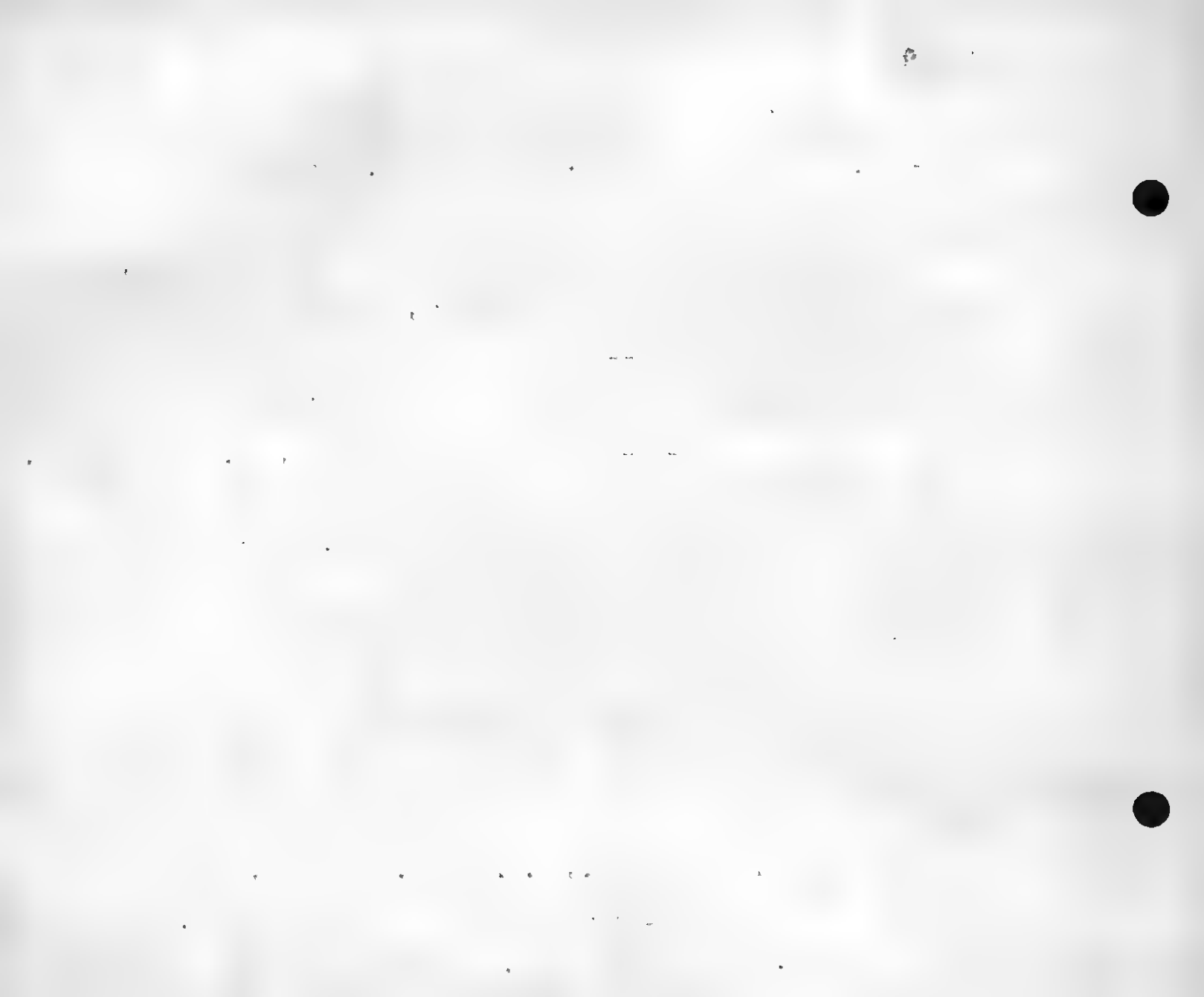
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07539

07530

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - St. Michaels				c. LENGTH OF STAY IN 1b 2 1/2 mos.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rio Vista Nursing Home				d. STREET ADDRESS St. Michaels			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First KATHERINE Middle LOUISE Last KRAUSE				4. DATE OF DEATH Month May Day 2 Year 1966			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 20, 1883	
9. AGE (In years last birthday) 82 yrs.		10. UNDER 1 YEAR Months 82 Days 0 Hours 0 Min.		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY ----			
13. FATHER'S NAME John Blumenthal				14. MOTHER'S MAIDEN NAME Matilda Rieker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 412-03-2251-D		17. INFORMANT Alfred Ossman, St. Michaels, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure - Chronic DUE TO atherosclerotic cardiac & cerebral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) advanced benign changes, marked cerebral degeneration				INTERVAL BETWEEN ONSET AND DEATH -----			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) advanced benign changes, marked cerebral degeneration				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1966 to 5-2 , 19 66 , that (I) (we) last saw the deceased alive on 5-2 , 19 66 , and that death occurred 8:40 PM , from the causes and on the date stated above.							
22a. SIGNATURE Guy M. Reeser, Jr.				22b. DATE SIGNED 5-2-66		22c. PHYSICIAN'S NAME (Type) GUY M. REESER, Jr., M.D.	
22d. ADDRESS St. Michaels, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/7/66		23c. NAME OF CEMETERY OR CREMATORY Schwartz Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR John A. Moran, Inc. 3000 E. Baltimore St.				25a. REC'D BY REGISTRAR MAY 4 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CORDOVA</u>			c. LENGTH OF STAY IN 1b <u>3 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CORDOVA</u>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print) First Middle Last <u>NELLIE SAMIS KUBLER</u>					4. DATE OF DEATH Month Day Year <u>5-8-66</u> 19 <u>66</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-24-1894</u>		9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>TALBOT, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>A. HENRY SAMIS</u>					14. MOTHER'S MAIDEN NAME <u>CLARA PHILLIPS</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>MARVIN P. KUBLER</u>		Address <u>12MS RIVER, N.D.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>many yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>24 July 1964</u> to <u>8 May 1966</u> , that (I) (we) last saw the deceased alive on <u>22 March 1966</u> , and that death occurred at <u>5 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Stefh Barney</u>					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10 May 66</u>		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <u>4-12-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		23d. LOCATION (City, town or county) (State) <u>HILLSBORO MD</u>		
24. FUNERAL DIRECTOR <u>Arthur Beach</u>					ADDRESS <u>Barton, MD</u>		25a. REC'D BY REGISTRAR <u>MAY 13 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07541

2532

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-Easton</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Talbot</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-Easton</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Agnes</u> Middle <u>Lena</u> Last <u>Lacey</u>				4. DATE OF DEATH Month <u>5</u> Day <u>5</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 3, 1902</u>	
9. AGE (in years last birthday) <u>63</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FACTORY</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Talbot, MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Sam - NEWMAN</u>			
14. MOTHER'S MAIDEN NAME <u>Stella Wilmer</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>222-105861</u>				17. INFORMANT <u>Edward Fisher</u> Address <u>Wilmington Del.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Coronary artery disease</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/27</u> , 19 <u>66</u> , to <u>4/12</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4/12</u> , 19 <u>66</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Kurt Lederer</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>KURT LEDERER</u>	
22d. ADDRESS <u>QUEEN ANNE MD.</u>				22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
<u>Burial</u>		<u>5-9-66</u>		<u>Newtown Cemetery</u>		<u>Talbot Md</u>	
24. FUNERAL DIRECTOR <u>James B. Maxwell</u> ADDRESS <u>Easton</u>				25a. REC'D BY REGISTRAR <u>MAY 18 1966</u>		25b. REGISTRAR'S SIGNATURE <u>John L. Judge</u>	

VR A15 (4)
15M 4-64

1. PLACE OF DEATH a. COUNTY talbot		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Royal Oak		c. LENGTH OF STAY IN 1b 20 YRS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) RURAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bessie Deggs McAYOY		4. DATE OF DEATH Month 5 Day 12 Year 1966	
5. SEX Female		6. COLOR OR RACE col	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-19-1899	
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 27 Hours 0 Min. 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. KIND OF BUSINESS OR INDUSTRY Domestic	
13. BIRTHPLACE (County & State, or foreign country) MARYLAND		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME Jasiah Deggs		16. MOTHER'S MAIDEN NAME Ida Stanley	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None		18. SOCIAL SECURITY NO. None	
19. INFORMANT JDA Hill		Address Royal Oak, Md.	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion + + + + + Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Chronic Arteriosclerotic Cardiovascular Disease 3 yrs. DUE TO (c) Hypertension DUE TO 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-12-1966 , to 5-12-1966 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 5:00 M, from the causes and on the date stated above.			
22a. SIGNATURE A. Nowell		22b. DATE SIGNED 5-14-66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5-16-66	
23c. NAME OF CEMETERY OR CREMATORY Mt. AUBURN CEM.		23d. LOCATION (City, town or county) (State) BALTO. Md.	
24. FUNERAL DIRECTOR James D. Doherty, Corton, Md.		25a. REC'D BY REGISTRAR MAY 16 1966	
25b. REGISTRAR'S SIGNATURE Charles J. Jones			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07534

1. PLACE OF DEATH
a. COUNTY ALBANY
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BRISTOL
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) DENTON
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) BRISTOL
e. STREET ADDRESS DENTON
f. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. MARYLAND b. COUNTY CAROLINE
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) DENTON
d. STREET ADDRESS DENTON
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First Middle Last
LAURA ANN MITCHELL
4. DATE OF DEATH
Month Day Year
MAY 8 1966

5. SEX F 6. COLOR OR RACE W 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH
FEB 28, 1878 9. AGE (In years, months, days)
88 yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home
10b. KIND OF BUSINESS OR INDUSTRY MD.
11. BIRTHPLACE (State or foreign country) MD.
12. CITIZEN OF WHAT COUNTRY USA

13. FATHER'S NAME SAMUEL PORTER
14. MOTHER'S MAIDEN NAME CHARITY JONES
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
16. SOCIAL SECURITY NO. NO
17. INFORMANT MRS. ROLAND GRIFFITH, DENTON, MD.
Address DENTON, MD.

18. CAUSE OF DEATH (Enter only one cause per line for a), b), and c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cerebral Arteriosclerosis
(c) Generalized arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH
7 1/2 hrs
725 hrs

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Chronic Passive congestions Auricular fibrillation
20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
ACTUAL SIGNATURE Harold B. Plummer M.D.
EXAMINER'S NAME (Type) Harold B. Plummer
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 5/14/66
Address (Street, city, town, or county)

22. BURIAL, CREMATION, DATE THEREOF
May 11, 1966
22b. NAME OF CEMETERY OR CREMATORY DENTON
22c. LOCATION (City, town, or country) DENTON MD.
23. FUNERAL DIRECTOR W. E. L. Moore, Denton
ADDRESS DENTON
24a. REC'D BY REGISTRAR MAY 18 1966
24b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rural Boy 201 20-1</i>	
c. LENGTH OF STAY IN 1b <i>5 days</i>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Memorial</i>			
3. NAME OF DECEASED (Type or print) First <i>Robert</i> Middle <i>Myers</i> Last		4. DATE OF DEATH Month <i>5</i> Day <i>7</i> Year <i>1966</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 10, 1883</i>
9. AGE (In years last birthday) <i>82 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABORER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>FARM</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Talbot, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Robert Myers</i>		14. MOTHER'S MAIDEN NAME <i>Laura</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates in service) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Easton Hosp. Rpts</i>		Address <i>Easton, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Peri-carditis</i> <i>491X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Resolved bronchopneumonia</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>1966</i> to <i>1966</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that death occurred at <i>6 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>E. C. H. Smith</i>		22b. DATE SIGNED <i>7 May 66</i>	
22c. PHYSICIAN'S NAME (Type) <i>E. C. H. Smith</i>		22d. ADDRESS <i>Easton, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <i>5-11-66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Paradise Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Talbot Md.</i>
24. FUNERAL DIRECTOR <i>James B. Cashels</i>		25a. REC'D BY REGISTRAR <i>OAT MAY 10 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			



FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a COUNTY <u>Talbot</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	c. LENGTH OF STAY IN lb <u>2hr</u>	c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Rural - Easton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) <u>Horace</u> First <u>Chover</u> Middle Last		4 DATE OF DEATH <u>5</u> Month <u>11</u> Day <u>19</u> Year <u>66</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4-18-89</u> 9. AGE (In years last birthday) <u>77</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of work on life event if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	11 BIRTHPLACE (State or foreign country) <u>Maryland</u>
12 CITIZEN OF WHAT COUNTRY <u>USA</u>		13 FATHER'S NAME <u>Unknown</u>	
14 MOTHER'S M maiden name <u>Unknown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16 SOC. SEC. NO. <u>216-54-908</u>		17 INFORMANT <u>Hospital Records</u> Address <u>Easton, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> 16a DUE TO (b) <u>House burned down</u> DUE TO (c) <u>lost.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>see 18b</u>	
20c. TIME OF INJURY Month, Day, Year <u>5-11 1966</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Home</u>	20f. (City or town) <u>W. Royal Oak Tal.</u> (County) <u>Md.</u> (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James M. Welty</u> MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>WELTY</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, or other disposition (Specify)	22b. DATE THEREOF <u>5-14-66</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Royal Oak Cem-</u>	22d. LOCATION (City or Town) <u>Talbot Md.</u> (County) (State)
24. FUNERAL DIRECTOR <u>James B. Mashnell</u> Address <u>Easton, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 18 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

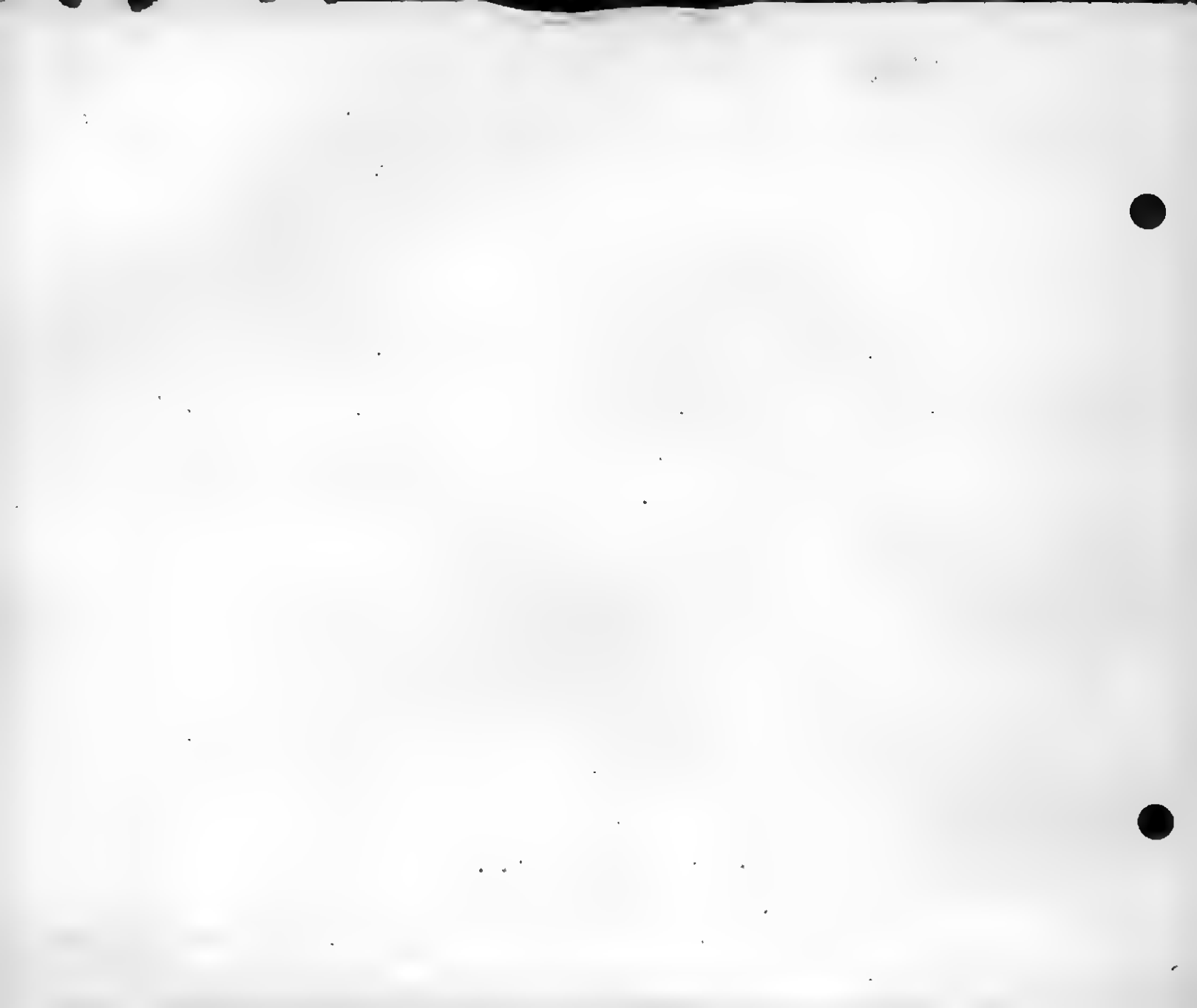
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
07546		2537									
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>QUEEN ANNE</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>7 hours</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GRASONVILLE</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Stephen</u> Middle <u>Edward</u> Last <u>Paswater</u>						4. DATE OF DEATH Month <u>May</u> Day <u>15</u> Year <u>1966</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 28, 1896</u>		9. AGE (In years last birthday) <u>69</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>CAROLINE Co. Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>WILLIAM E PASWATER</u>						14. MOTHER'S MAIDEN NAME <u>LULA M. WILCOX</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>128-12-9390</u>		17. INFORMANT <u>MRS. MABEL C. PASWATER</u> Address <u>GRASONVILLE MD.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchogenic carcinoma</u> <u>621</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>MAY 15</u> , 19 <u>66</u> , and that death occurred at <u>5:40</u> A.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Robert W Trever</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/15/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert W. Trever</u>						22d. ADDRESS <u>M. D. Easton, Maryland 5/15/66</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5/18/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CHESTERFIELD</u>		23d. LOCATION (City, town or county) (State) <u>CENTREVILLE MD.</u>					
24. FUNERAL DIRECTOR <u>Edgar L. Lane Church Hill Md.</u>						25a. REC'D BY REGISTRAR <u>MAY 24 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

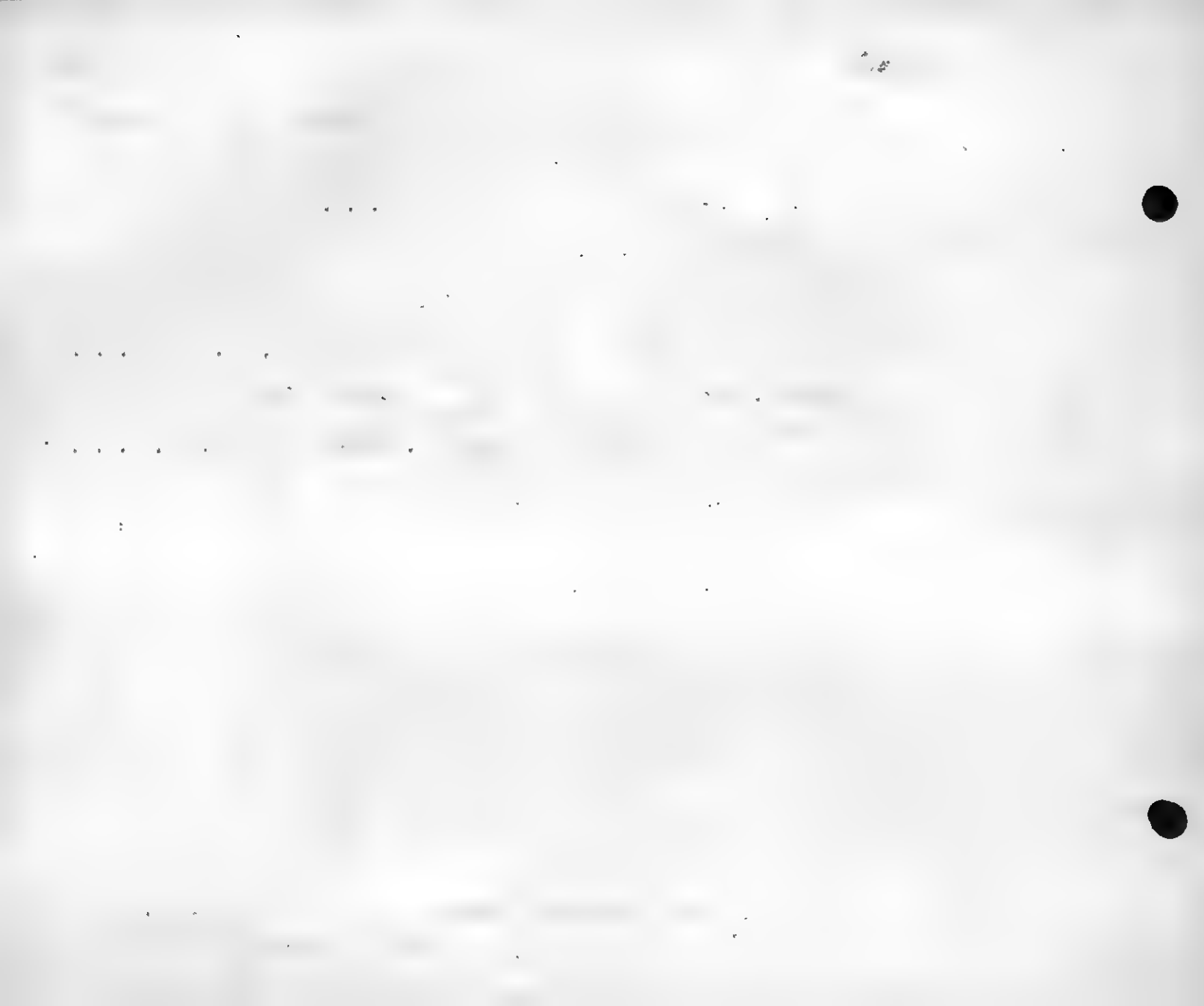
1. PLACE OF DEATH a. COUNTY TAIBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Preston - Rural	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL		d. STREET ADDRESS Choptank	
3. NAME OF DECEASED (Type or print) First MARIE Middle Louise Last PERRY		4. DATE OF DEATH Month 5 Day 23 Year 1966	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 16, 1884
9. AGE (In Years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 81	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Caroline Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David F. Perry		14. MOTHER'S MAIDEN NAME Mary Isabelle Gootee	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-40-7252	
17. INFORMANT W. Fred Perry, Preston, Maryland, RFD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) General debility DUE TO (b) Cerebral arteriosclerosis DUE TO (c) Senility CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of femur		INTERVAL BETWEEN ONSET AND DEATH Uncertain	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Robert W. Trever		22b. DATE SIGNED 5/23/66	
22c. PHYSICIAN'S NAME (Type) Robert . W. Trever		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Easton, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 25, 1966	
23c. NAME OF CEMETERY OR CREMATORY Bethesda Church Cemetery		23d. LOCATION (City, town or county) (State) Preston, Maryland	
24. FUNERAL DIRECTOR Frankton Funeral Home Frederickburg		25a. REC'D BY REGISTRAR JUN 2 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (If possible, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
CERTIFICATE OF DEATH																			
1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton					c. LENGTH OF STAY IN 1b 8 days 7 hrs.					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Memorial Hospital					d. STREET ADDRESS R.F.D. # 1					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Marjorie Middle Olevia Last Pender					4. DATE OF DEATH Month 5 Day 13 Year 1966														
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 10, 1915		9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months 5 Days 13		IF UNDER 24 HRS. Hours 7 Min. 00							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework					10b. KIND OF BUSINESS OR INDUSTRY Home					11. BIRTHPLACE (County & State, or foreign country) Dorchester County, Md.					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Charles W. Spry					14. MOTHER'S MAIDEN NAME Sarah Jolley														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. Unknown					17. INFORMANT Russell L. Pinder, Hurlock, Md. R.F.D. # 1					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral embolism 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mural cardiac thrombus DUE TO (c) Atrial flutter due to hypertension and atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH 3 days Uncertain									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.																			
22a. SIGNATURE Robert W. Trever										22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) Robert W. Trever										22d. ADDRESS M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF May 17, 1966		23c. NAME OF CEMETERY OR CREMATORY Petersburg Cemetery			23d. LOCATION (City, town or county) (State) Near Hurlock, Md.									
24. FUNERAL DIRECTOR Trampton Trampton Home Funeral Home										25. REG'D BY REGISTRAR MAY 23 1966					25a. REGISTRAR'S SIGNATURE J. Charles Judge				



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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <i>Talbot</i>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Queen Anne</i>					
b. CITY OR TOWN (If outside corporate limits, write nearest city and nearest town) <i>St. Michaels</i>					c. LENGTH OF STAY IN 1b <i>17.2</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS <i>Grasonville</i>					
3. NAME OF DECEASED (Type or print) <i>Mary</i> First <i>Rhodes</i> Middle <i>Rhodes</i> Last					4. DATE OF DEATH Month <i>May</i> Day <i>3</i> Year <i>1966</i>					
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>June 17, 1871</i>		9. AGE (in years last birthday) <i>94</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Lewes, Delaware</i>			12. CITIZEN OF WHAT COUNTRY <i>USA</i>			
13. FATHER'S NAME <i>James A. Johnson</i>					14. MOTHER'S MAIDEN NAME <i>Unknown</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <i>James Rhodes--Glen Burnie, Maryland</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> (c) <i>19 yr</i>								INTERVAL BETWEEN ONSET AND DEATH <i>48 hr</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>6-16</i> , 19 <i>66</i> to <i>31 May</i> , 19 <i>66</i> , that (I) was last saw the deceased alive on <i>1 May</i> , 19 <i>66</i> , and that death occurred at <i>5:00</i> P.M. from the causes and on the date stated above.										
22a. SIGNATURE <i>R. Lane Wroth</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <i>31 May 66</i>		
22c. PHYSICIAN'S NAME (Type) <i>R. Lane Wroth</i>				22d. ADDRESS <i>St. Michaels, Maryland</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>May 6</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Chesterfield</i>			23d. LOCATION (City, town or county) (State) <i>Centreville, Maryland</i>		
24. FUNERAL DIRECTOR <i>Edgar L. Lane</i>				ADDRESS <i>Church Hill, Md.</i>			25a. REC'D BY REGISTRAR <i>MAY 6 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND Item #3 File # <u>7550</u> <u>7541</u> Item # <u>1</u> File # <u>1</u>											
1. PLACE OF DEATH a. COUNTY TALBOT b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HOUSE ON THE HILLS EASTON 4441 Rosalee Towers Records						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) DENTON d. STREET ADDRESS ROUTE # 3 Box 95 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ELIZABETH CALLAWAY 5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH JULY 28, 1881 9. AGE (in years last birthday) 85 1/2 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home 10b. KIND OF BUSINESS OR INDUSTRY at home 11. BIRTHPLACE (County & State, or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? USA						13. FATHER'S NAME JONATHAN TOWERS 14. MOTHER'S MAIDEN NAME MINERVA CALLAWAY 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. (If give war or dates of service) 17. INFORMANT JOHN R. RECARDS Address DENTON					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pragmium cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4X DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from Sep 65, 19 to 20 May, 1966, that (I) (we) last saw the deceased alive on 14 May 1966, and that death occurred at 10 45 P.M. from the causes and on the date stated above. 22a. SIGNATURE <u>Stephen P. Carnegie</u> 22b. DATE SIGNED <u>22 May 66</u> 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> 23b. DATE THEREOF <u>May 24, 1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>DENTON</u> 23d. LOCATION (City, town or county) (State) <u>DENTON MD.</u> 24. FUNERAL DIRECTOR <u>Charles Moore Denton</u> 25a. REC'D BY REGISTRAR <u>MAY 26 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07551

11542

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> c. LENGTH OF STAY IN 1b <u>1 1/2 hr.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL EASTON</u> d. STREET ADDRESS <u>"Waverly"</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>James (Wilson) Speer</u> First Middle Last				4. DATE OF DEATH <u>MAY 2 1966</u> Month Day Year			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-8-1892</u> 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>ELECTRICAL ENG</u>		9. AGE (In years last birthday) <u>74</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) <u>PITTSBURG, PENNA</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>BREADING SPEER</u>				14. MOTHER'S MAIDEN NAME <u>EMMA WILSON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>087-03-8563</u>		17. INFORMANT <u>MRS. CECIL W. SPEER</u> Address <u>Box 474 EASTON, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>163X</u> DUE TO <u>Continued from the lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1950</u> to <u>2 May 1966</u> , that (I) (we) last saw the deceased alive on <u>2 May 1966</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Thorston Harrison</u>				22b. DATE SIGNED <u>2 May 66</u>		22c. PHYSICIAN'S NAME (Type) <u>THORSTON HARRISON</u>	
22d. ADDRESS <u>Center, Navy Land</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>5-2-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Hill</u>		23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR <u>Charles Judge</u> ADDRESS <u>Easton, Md</u>				25a. REC'D BY REGISTRAR <u>MAY 4 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

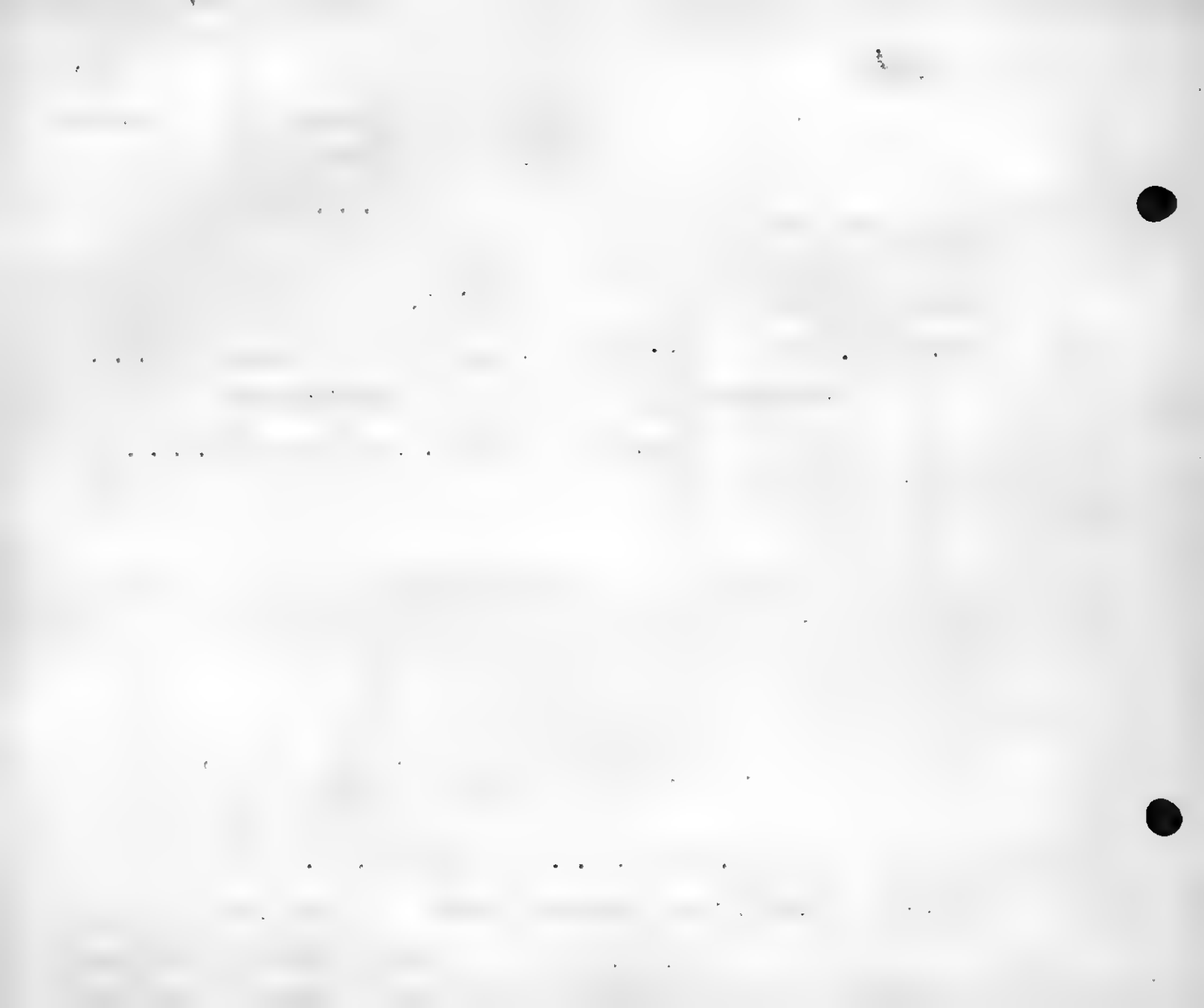


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

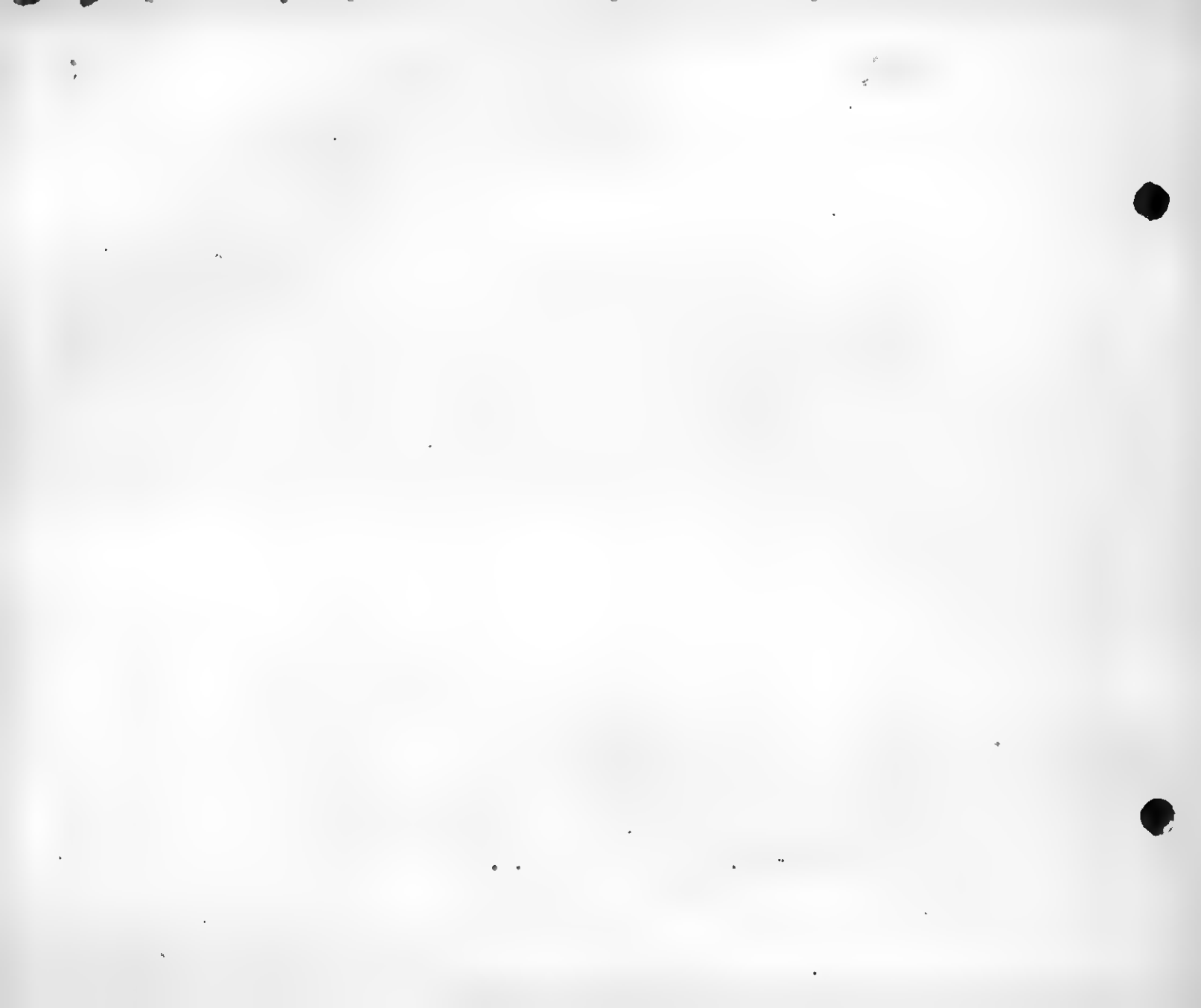
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
07552					07543				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		a. STATE			b. COUNTY	
Talbot			Easton		Maryland			Dorchester	
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				
15 1/2 hr.					Hurlock - Rural				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS				
Memorial Hospital					R.F.D. # 1- Box 53A				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
Emma Mac Spry					Month 5 Day 18 Year 1966				
5. SEX					6. COLOR OR RACE				
Female					Negro				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					8. DATE OF BIRTH				
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					July 2, 1921				
9. AGE (In years last birthday)					10. AGE (In years last birthday)				
44 yrs.					44 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY				
Assistant forelady					Hurlock Dress Factory				
11. BIRTHPLACE (County & State, or foreign country)					12. CITIZEN OF WHAT COUNTRY?				
Dorchester County					U.S.A.				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Charles Parker					Catherine Camper				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.				
No					220-01-2448				
17. INFORMANT					Address				
Weldon W. Spry, Hurlock, Md.					R.F.D.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Shock									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO Gram negative bacteremia									
DUE TO Acute parametritis									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year									
Hour a.m. p.m. 19									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from May 17, 1966, to May 18, 1966, that (I) (we) last saw the deceased alive on May 18, 1966, and that death occurred at 8:30 A.M. from the causes and on the date stated above.									
22a. SIGNATURE									
Robert W. Trever									
22b. DATE SIGNED									
May 19, 1966									
22c. PHYSICIAN'S NAME (Type)									
Robert W. Trever, M.D.									
22d. ADDRESS									
Easton, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)									
Burial									
23b. DATE THEREOF									
May 22, 1966									
23c. NAME OF CEMETERY OR CREMATORY									
Petersburg Cemetery									
23d. LOCATION (City, town or county) (State)									
Near Hurlock, Maryland									
24. FUNERAL DIRECTOR									
Trampton Funeral Home Frederick									
25a. REC'D BY REGISTRAR									
MAY 23 1966									
25b. REGISTRAR'S SIGNATURE									
Charles Judge									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MEMORIAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL CENTREVILLE</u> d. STREET ADDRESS <u>XX</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>R.</u> Last <u>STUBBS</u>				4. DATE OF DEATH Month <u>5</u> Day <u>24</u> Year <u>1966</u>							
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/1/1901</u>		9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LANDSCAPE GARDNER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>THOMAS STUBBS</u>						14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service) <u>217-30-8125</u>		17. INFORMANT <u>MRS. WM. STUBBS - CENTREVILLE MD.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the lung</u> '63x DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>Uncertain</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u> </u> , 19 <u> </u> to <u> </u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>10:15</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Robert W. Trever</u>				22b. DATE SIGNED <u>5/25/66</u>		22c. PHYSICIAN'S NAME (Type) <u>Robert W. Trever</u> M.D.		22d. ADDRESS <u>Easton, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY 28</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SUDLERSVILLE</u>		23d. LOCATION (City, town or county) (State) <u>SUDLERSVILLE MD</u>					
24. FUNERAL DIRECTOR <u>Edgar L. Lane</u>				25a. REC'D BY REGISTRAR <u>HUN 1 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Talbot MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Easton			c. LENGTH OF STAY IN 1b 21 years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Easton				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 411 N. Aurora Street					d. STREET ADDRESS 411 N. Aurora Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sarah Melvina Sullivan					4. DATE OF DEATH Month May Day 14 Year 1966				
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/23/1883		9. AGE (in years last birthday) 82 yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Talbot Maryland			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Davis					14. MOTHER'S MAIDEN NAME Georgianna Saulsbury				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. none		17. INFORMANT Address Percy B. Sullivan, Easton, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4-2-01 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A5HD DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General debility									INTERVAL BETWEEN ONSET AND DEATH 5 min years-
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from May 8, 1966 to May 14, 1966 , that (I) (we) last saw the deceased alive on May 14, 1966 , and that death occurred at 12:35 PM , from the causes and on the date stated above.									
22a. SIGNATURE Dale R. Kollman M.D.								22b. DATE SIGNED May 16, 1966	
22c. PHYSICIAN'S NAME (Type) Dale R. Kollman, M.D.			22d. ADDRESS 12 N. Hanson St., Easton, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 5/17/1966		23c. NAME OF CEMETERY OR CREMATORY Spring Hill		23d. LOCATION (City, town or county) (State) Easton, Md.		
24. FUNERAL DIRECTOR ADDRESS MAURICE E. NEUNAM & SON, Easton, Md.						25a. REC'D BY REGISTRAR MAY 17 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

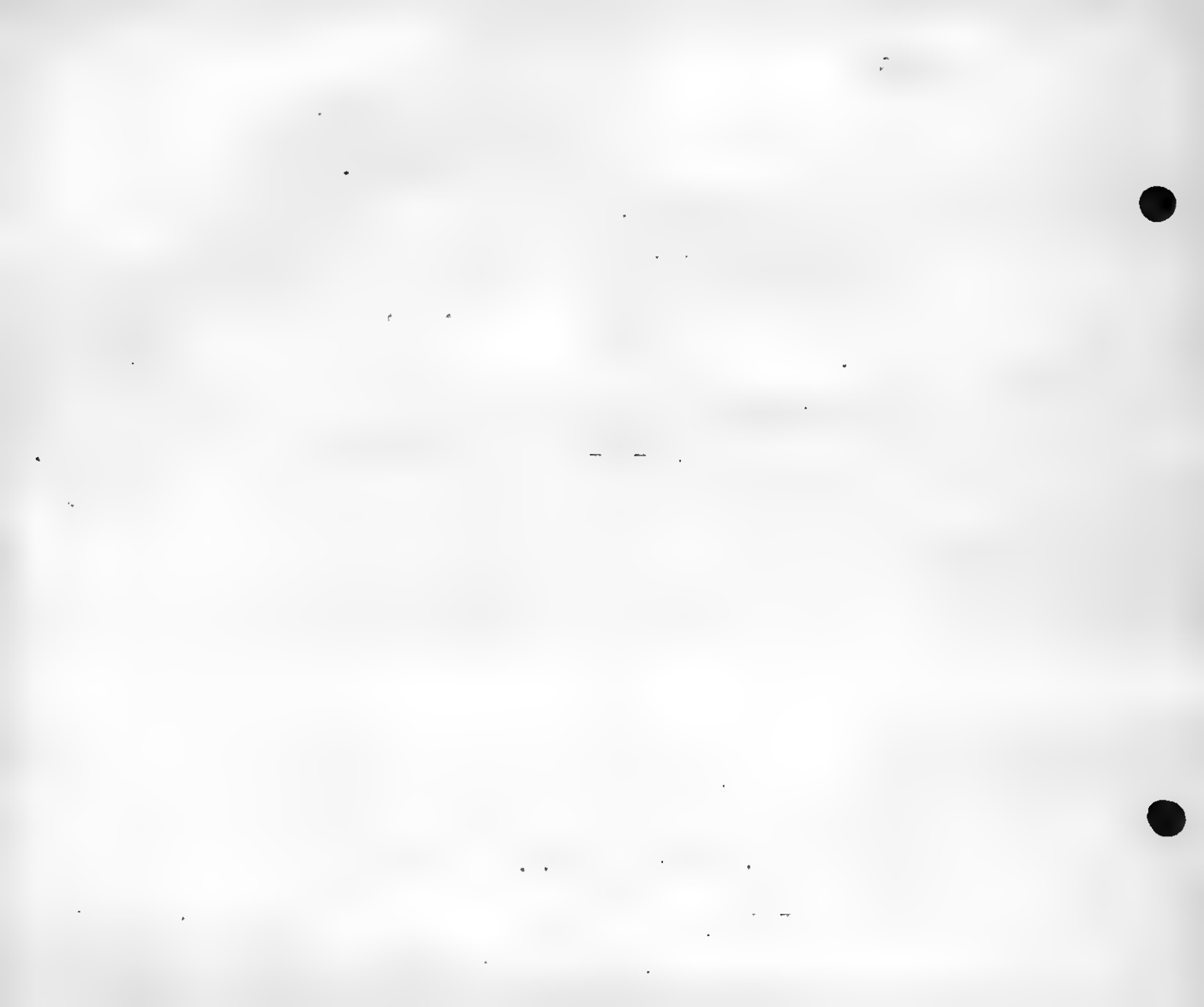
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH					37546					
1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Caroline</i> ✓					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Easton</i>			c. LENGTH OF STAY IN 1b <i>8 days - 2 1/2 hrs</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Greensboro</i>			d. STREET ADDRESS <i>None</i>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Memorial Hospital</i>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <i>Flarence</i> Middle <i>Elizabeth</i> Last <i>Thornton</i>					4. DATE OF DEATH Month <i>May</i> Day <i>30</i> Year <i>1966</i>					
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Mar. 16, 1895</i>		9. AGE (In years last birthday) <i>71</i> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>05</i> Days <i>2</i> Hours <i>00</i> Min. <i>00</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>			11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>William Hammond</i>					14. MOTHER'S MAIDEN NAME <i>Bright</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>			16. SOCIAL SECURITY NO. <i>216-07-4543</i>		17. INFORMANT Address <i>Lawrence Thornton Hillsboro, Md.</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> <i>13 2X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral arteriosclerosis</i> DUE TO (c) <i>Unknown</i>								INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>May 30, 1966</i> to <i>May 30, 1966</i> , that (I) (we) last saw the deceased alive on <i>May 30, 1966</i> and that death occurred at <i>5:48</i> M, from the causes and on the date stated above.										
22a. SIGNATURE <i>Robert W. Trever</i>					ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. <i>M.D.</i>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>6/1/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Robert W. Trever</i>					22d. ADDRESS <i>Easton, Maryland</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>6-2-66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Greensboro</i>			23d. LOCATION (City, town or county) (State) <i>Greensboro, Maryland</i>			
24. FUNERAL DIRECTOR <i>E. Boulaire</i>					ADDRESS <i>Greensboro, Md.</i>		25a. REC'D BY REGISTRAR <i>JUN 3 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



1 (M)
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07556		07547	
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>rural</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
c. LENGTH OF STAY IN ID <u>12 years</u>		d. STREET ADDRESS <u>RFD # 3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RFD # 3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Lee Troth</u>		4. DATE OF DEATH Month Day Year <u>May 24 19 66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 3, 1871</u>
9. AGE (in years last birthday) <u>94</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Corbett</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Jane Piper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-54-9092</u>	
17. INFORMANT <u>Mrs. Robert B. Grabbon, Easton, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senile arteriosclerosis + infarction of AGE</u> 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Lewis D. Welch</u>		22. DATE SIGNED <u>5-24-66</u>	
EXAMINER'S NAME (Type) <u>WELCH</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>5/26/1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>MAURICE E. NEUNAM & SON, Easton, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 26 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
07557					07548					
1. PLACE OF DEATH a. COUNTY <i>Talbot</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Trappe</i>			c. LENGTH OF STAY IN 1b <i>2 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Oxford</i>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Home of Mr. & Mrs. Alex Green</i>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Middle Last		4. DATE OF DEATH		Month Day Year				
<i>Maggie Estelle Willey</i>						<i>May 24</i>		<i>19 66</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/15/1874</i>	9. AGE (In years birthdate) <i>91</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Dorchester Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>William H. Lewis</i>				14. MOTHER'S MAIDEN NAME <i>Susan A. Fairbanks</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>			16. SOCIAL SECURITY NO. <i>215-38-2330</i>		17. INFORMANT <i>Lee Willey, Oxford, Md.</i>				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral arteriosclerosis</i> <i>334x</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
		19								
21. I certify that (I) (this hospital) attended the deceased from <i>March 15, 1966</i> , to <i>5-24</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>March 15</i> , 19 <i>66</i> , and that death occurred at <i>10⁰⁵</i> P. M. from the causes and on the date stated above.										
22a. SIGNATURE <i>Robert W. Trever</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <i>5-25-66</i>		
22c. PHYSICIAN'S NAME (Type) <i>R. D. 3</i>				22d. ADDRESS <i>Easton, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>5/27/1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Oxford Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Oxford, Md.</i>				
24. FUNERAL DIRECTOR <i>MAURICE E. NEUNAM & SON, Easton, Md.</i>				ADDRESS		25a. REC'D BY REGISTRAR DATE <i>MAY 27 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

1957

Letter

Large

Small

Room of Mr. & Mrs. John

and the family

Family

in

1957

Room

John W. Lewis

Room

John W. Lewis

1957-1958

in

Room 1957-1958

John W. Lewis

Room

1957-1958